LITTLE TRAVERSE BAY BANDS OF ODAWA INDIANS
HEARING AID PROGRAM APPLICATION

Email: PRCfax@ltbbodawa-nsn.gov
Fax: 231-242-1617

DIRECT BILL REQUEST

I, _____ , have reviewed the following:
PLEASE PRINT YOUR FULL NAME

- **<u>YOU MUST APPLY PRIOR TO RECEIVING SERVICES TO BE ELIGIBLE FOR PROGRAM</u>**
- This program covers $2,500 per hearing aid every 4 years.
- If the patient establishes the medical necessity for bilateral hearing aids, two will be covered at the above benefit level.
- **Documentation of Medical Necessity** from the doctor must be submitted with the application.
- The Elder's Hearing Aid Program is considered the PAYER OF LAST RESORT. This means **<u>all</u>** other insurances **must be billed prior** to the Elder's Hearing Aid Program issuing payment.
- The Elder is responsible for completing and submitting this application in **its entirety**, including submitting their *Tribal ID, any insurance information, and the Documentation of Medical Necessity (hearing test)*.
- If approved, you will be issued an approval number that obligates this benefit for your use. This approval will be valid for 6 months from the date of the approval letter. If you do not use your benefit in the allotted time, the funds will be released back into the program.

Expectations of Patient:

- The patient will participate in the periodic maintenance of the hearing aid units including cleaning, adjustments, and battery changes.
- The patient will notify their hearing aid provider of any issues or problems that need to be addressed within 30 days of receiving the unit.

I UNDERSTAND THAT FAILURE TO FOLLOW THESE INSTRUCTIONS WILL RESULT IN MY APPLICATION BEING DENIED. I ALSO UNDERSTAND IF I PROVIDE FALSE INFORMATION CAN RESULT IN REFERRAL TO THE PROSECUTING ATTORNEY FOR FRAUD, AND/OR RECOVERY OF FUNDS PAID ON MY BEHALF.

_____ SIGNATURE AND DATE

_____ DATE OF BIRTH

_____ MAILING ADDRESS

_____ TRIBAL ID #

_____ CITY/STATE/ZIP

_____ PHONE #

_____ PROVIDER NAME AND ADDRESS

_____ PROVIDER PHONE #

☐ I need help finding a hearing aid provider in my area. **Please ensure your phone accepts voicemails in case we are attempting to contact you.**

FOR OFFICE USE ONLY | LEAVE BLANK

Documentation Checklist

- ☐ Did the patient submit a completed application?
- ☐ Did the patient submit Documentation of Medical Necessity?
- ☐ Did the patient submit a copy of their Tribal ID?
- ☐ Does the patient have any other insurance?
- ☐ Did the patient submit a copy of the Provider Invoice?
- ☐ Did the provider supply a W-9?

YES/NO Has the patient already utilized the Elders Hearing Aid Program in the last 4 years?

Notes:

APPROVAL #: **CHECK #:**

☐ APPROVED ☐ DENIED

APPROVAL'S SIGNATURE **DATE**

APPROVAL'S PRINTED NAME AND POSITION TITLE

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What happens next?

#1 The application is submitted to the Health Services Navigator (HSN) for review.

#2 The HSN will review the application, treatment plan, and all other supporting documents.

#3 A letter will be submitted to the patient with the determination of coverage.

If **approved**, the patient may now coordinate with their doctor and schedule appointments for the services.

If **denied**, and the patient disagrees with the determination, then they may submit a ***written*** appeal to the Purchased/Referred Care Manager.

Address:
LTBB Health Department
ATTN: Hearing Aid Program
1260 Ajijaak Avenue
Petoskey, MI 49770

A fillable appeal form is attached to this application.

Questions?
Call 231-242-1600 (PRC)

LITTLE TRAVERSE BAY BANDS OF ODAWA INDIANS

HEARING AID PROGRAM APPLICATION

APPEAL OF DENIAL

PLEASE PRINT YOUR FULL NAME _____ DATE OF BIRTH _____

ADDRESS _____ ENROLLMENT # _____

CITY/STATE/ZIP _____ PHONE # _____

Dear Purchased/Referred Care (PRC) Manager for LTBB,

I have recently received notification from the Health Services Navigator that I have been denied coverage through the Elders Hearing Aid Program. However, I believe this decision should be reconsidered for the following reasons:

_____

_____

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In light of the information above, I respectfully request that you reconsider coverage for my services through the Elders Hearing Aid Program. If you have any questions or need further information, please contact me using the information listed above.

Thank you for your attention on this matter.

SIGNATURE _____ DATE _____